DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/14/2011	
	PROVIDER OR SUPPLIER D TRANSITIONAL C	ARE AND REHAB-FORT WAYNE	'	STREET A	DDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE VAYNE, IN46815	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
LABORATOR	deficiencies relaticited at F 157 and IN00095303-Uns of evidence. Survey dates: Separatility number: Provider number: 100 Aim number: 100 Survey team: Ann Armey, RN Carol Miller, RN Carol Miller, RN Carol Miller, RN Census bed type: SNF/NF: 142 Total: 142 Census payor typ Medicare: 8 Medicaid: 105 Other: 29 Total: 142 Sample: 9	ostantiated. Federal/state ed to the allegations are d F 282. Substantiated due to lack otember 12, 13, 14, 2011 000153 : 155249 0266910 TC		0000	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CON	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155249	A. BUILDING	j	00	09/14/2	
		100210	B. WING	DEET A1	DDRESS, CITY, STATE, ZIP CODE	00/11/2	
NAME OF I	PROVIDER OR SUPPLIER				RANDY CHASE COVE		
KINDRE	D TRANSITIONAL C	CARE AND REHAB-FORT WAYNE			/AYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL	PREF	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	G	DEFICIENCE)		DATE
		_					
F0157 SS=D	A facility must immoresident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant changemental, or psychosocial statuconditions or clinical alter treatment significant in the psychosocial statuconditions or clinical term treatment significant in the psychosocial statuconditions or clinical alter treatment significant in the facility as specified. The facility must a resident and, if known in the same a change in reside state law or regular paragraph (b)(1) of the facility must resident the address resident's legal registerity member.	nediately inform the with the resident's physician; by the resident's legal an interested family member accident involving the ults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or as in either life threatening and complications); a need to inficantly (i.e., a need to sting form of treatment due quences, or to commence a ment); or a decision to ge the resident from the d in §483.12(a). Ilso promptly notify the pown, the resident's legal interested family member ange in room or roommate accified in §483.15(e)(2); or ant rights under Federal or actions as specified in	F0157		The nursing center request	S	10/14/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155249	B. WIN			09/14/2	011
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	· ·		6006 BF	RANDY CHASE COVE		
	D TRANSITIONAL (CARE AND REHAB-FORT WAYNE	<u> </u>		VAYNE, IN46815		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	•	TAG		1	DATE
	1	notify the physician when			that this plan of correction	be	
		low blood sugar (Resident			considered its credible		
	1 '	medication was not			allegation of compliance.		
		ent #I). This deficiency			0.1 0.1		
	affected 2 of 8 re	-			Submission of the respons		
	medications and				and Plan of Correction is r	ot a	
	reviewed, in a sa	ample of 9.			legal admission that a		
					deficiency exists or that th		
	Findings include	e:			statement of deficiency wa		
					correctly cited and is also	not	
					to be construed as an		
	1. The closed cli	nical record of Resident			admission of interest again	ıst	
	#D was reviewed	d on 9/12/11 at 3:00 p.m.			the nursing center, the		
	and indicated the	e resident was admitted to			administrator, or any		
	the facility on 7/	22/11 with diagnoses			employee, agents, or other		
	I -	but were not limited to,			individuals who draft or m		
		nt diabetes mellitus, and			be discussed in the respons	-	
	_	ent #D was discharged to			and Plan of Correction. In		
	home on 8/4/11.				addition, preparation and		
					submission of the Plan of		
	The August and	September 2011 MAR			Correction does not consti	tute	
	_	ministration Record)			an admission or agreement		
	I '	ident was to have blood			any kind by the nursing ce		
		fore meals, at bed time			of the truth of any facts all		
	~	The MARs indicated if			or the corrections of	-0**	
		was less than 60 and the			conclusions set forth in thi	c c	
	1	ponsive give 4 ounces of			allegation by the survey		
	1	notify the physician for					
	further orders.	nonly the physician for			agency.		
	Turtifer orders.				A acordinals, the margine		
	0 0/2/11 -4 2 1	1			Accordingly, the nursing		
	On 8/2/11 at 2:11 a.m., progress notes				center has prepared and		
		ent #D was not feeling			submitted this Plan of		
		dent's blood sugar was			Correction prior to the		
	low at 43. The re	esident was given a can of			resolution of appeal of this	3	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPI	LETED
		155249	B. WIN			09/14/2	2011
NAME OF S	OD OLUBER OR GURRI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF	PROVIDER OR SUPPLIE	R		6006 BI	RANDY CHASE COVE		
KINDRE	D TRANSITIONAL	CARE AND REHAB-FORT WAYNE		FORT V	VAYNE, IN46815		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		,		TAG		1	DATE
	ensure and "Res (Resident) now WNL				matter solely because of the		
	(Within Normal	Limit)"			requirements under State		
					Federal law that mandates		
		ocumentation the			submission of the Plan of		
	physician was n	otified.			Corrections a condition to		
			1		participate in the Title 18	and	
		onitoring Flow Sheet			Title 19 programs. The		
		ood sugar was retaken, and			submission of Plan of		
	was 95. There w	as a check mark on the			Correction within this tim	e	
	flow sheet indic	ating the physician was			frame should in no way be	9	
	not notified.				construed as an admission	of	
					non-compliance by the nu	rsing	
	During interview	v, on 9/14/11 at 9:00 a.m.,			center.		
	Unit Manager #3	3 indicated she was not					
	able to find any	faxes or documentation					
	indicating the pl	nysician had been notified			F157		
	about Resident #	D's low blood sugar.					
		•			I. 1. Resident #D no long	ger	
					resides in the nursing cent		
	2. Resident I's r	ecord was reviewed on			therefore, no further corre		
	9/12/11 at 1:00 l	P.M. Resident I's			action could be taken for t		
		led but were not limited	1		resident.		
	1 -	nxiety, and chronic pain.			2. The medication, Relist	or.	
	,,,,				was on National Backorde	· ·	
	On 9/7/11 a nhy	vsician progress note			Thus, a physician order w		
		ent #I was experiencing			obtained for Resident #I to		
		dominal pain and nausea.			discontinue the medication		
	20115tipation, abi	aominia pam ana masoa.			with an order for a		
	On 9/7/11 a phy	vsician's order indicated			replacement medication.		
		nausea medication) 12 mg			replacement incurcation.		
		subcutaneously every 48			II. The glucometer flow		
	_	subcutaneously every 46			records of all residents ha		
	hours.					ve	
	TO 1 1 1	A.1			been reviewed with no		
	I The Medication	Administration Record	1		additional concerns noted		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155249	B. WIN			09/14/2011	
			F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				RANDY CHASE COVE		
KINDREI	O TRANSITIONAL C	CARE AND REHAB-FORT WAYNE	<u> </u>	I	VAYNE, IN46815		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DATE	
	dated September	2011 indicated on					
	9/10/11 and 9/12	/11 at 8:00 A.M. the			The Medication		
	medication Relis	tor was circled as not			Administration Records		
	given.				(MARs) of all residents ha	ve	
					been reviewed in an effort	to	
					identify any other medicat	ion	
	On 9/13/11 at 10	:00 A.M. the Assistant			concerns. No other concer	rns	
	Director of Nursi	ing (ADON) was			were identified.		
	interviewed in re	gard to the medication,					
	Relistor, which v	vas circled as not given			III. Licensed nurses have		
	on 9/10 and 9/12	/11. The ADON			received in-service educati	ion	
	indicated the med	dication Relistor was not			relative to notification of		
	in the facility and	d the Nurse on Saturday			changes, including but not		
		got to call the pharmacy			limited to blood sugar read		
	and notify the ph	-			outside of call parameters	-	
	, ,				medication concerns.		
	There was no do	cumentation the					
	physician was no				A performance improveme	ent	
					tool has been developed th		
	The Diabetic Mo	nitoring Flow Sheet			Unit Managers, or designe		
		od sugar was retaken, and			will utilize to monitor dail		
		as a check mark on the			scheduled days of work, fo	' I I	
		ting the physician was			days, compliance with		
	not notified.	6 2 F) 2 1, wo			physician notification of		
	1100 110 01110 01.				abnormal blood sugar resu	lts	
	During interview	y, on 9/14/11 at 9:00 a.m.,			and medication concerns.		
		indicated she was not			identified concerns will be	· I	
		faxes or documentation			promptly addressed with		
	_	ysician had been notified			responsible individual(s).		
		D's low blood sugar.			1 coponision marriadal(s).		
	about Resident π	D 5 10 W 01000 Sugui.			IV. DNS, or designee, wil	1	
	This Federal tag	relates to Complaint			review findings weekly an		
	IN00094960.	relates to Complaint			report to PI committee	u	
	11100074700.				_		
					monthly for 6		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249		(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING 00 COMPL B. WING 09/14/20			ETED		
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
KINDREI	O TRANSITIONAL O	CARE AND REHAB-FORT WAYNE		1	RANDY CHASE COVE /AYNE, IN46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	6	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) months to determine need		(X5) COMPLETION DATE
	3.1-5(a)(2) 3.1-5(a)(3)				continued monitoring thereafter. V. Completion Date: October 14, 2011	ioi	
F0282 SS=E	facility must be proin accordance with plan of care. Based on observation record review, the physician orders administering a reproviding a treatmotifying the physician was low (Form the facility also policy for measure to assure proper the injection cape (Peripherally Insuline (Resident #EThis deficiency as whose medication reviewed in a sare Findings include 1. The closed clist #C was reviewed.	medication (Resident #I), ment (Resident #C), and ysician when a blood desident #D). failed to follow their ring an external catheter placement and changing s of a resident with PICC erted Central Catheter) (3) ffected 4 of 8 residents in and treatments were inple of 9.	F0	282	F282 I. 1. & 2. Residents #0 #D no longer reside in the nucenter, therefore, no further corrective action could be take for these residents. 3. Resid #E's PICC dressing and PICC caps were changed. 4. The medication, Relistor, was on National Backorder. Thus, a physician order was obtained Resident #I to discontinue the medication with an order for replacement medication. II. Treatment Administration Records (TARs) and the Intravenous Flow Records of residents have been reviewe an effort to identify any other dressing or PICC/IV concernwith no concerns noted. The glucometer flow records of all residents have been reviewe with no additional concerns noted. The Medication Administration Records (MAR of all residents have been reviewed in an effort to identiany other medication concerns	rising ken ent C d for e a The d in s Il d Rs)	10/14/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		155249	B. WIN			09/14/201	11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	D TO A NOITION ALL	NADE AND DELIAD FORT WAYA	_		RANDY CHASE COVE		
KINDREI	D TRANSITIONAL C	CARE AND REHAB-FORT WAYN	IE	FORTV	VAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG			DATE
	l	an abdominal wound that			with corrective action taken a necessary. III. Licensed Nur		
	· •	for MRSA (Methicillin			have been in-serviced relative		
		lococcus Aureus).			following physician orders,	1	
		discharged to home on			including but not limited to		
	8/19/11.				medication and treatment		
					administration, blood sugars		
	Admission order	s, dated 8/9/11, indicated			outside of call parameters, a PICC line policies. Performa		
	the abdominal w	ound was to be cleaned			improvement tools have bee		
	with normal salir	ne, Iodoform packing, 1/2			developed that Unit Manage	rs, or	
		l covered with a dry			designee, will utilize to monit		
	sterile dressing th	-			daily, on scheduled days of v		
					for 30 days, compliance with following physician orders. A		
	On 8/10/11 at 5:1	10 p.m., progress notes			identified concerns will be	Tily	
		nt #C was upset because			promptly addressed with		
	she had not recei	•			responsible individual(s). IV.		
					DNS, or designee, will review		
		e day shift. The resident			findings weekly and report to		
		s suppose to receive the			committee monthly for 6 mor to determine need for continu		
	1	eight hours and the			monitoring thereafter. V.		
		ne last night at 10:00			Completion Date: October 1	4,	
	p.m. but had not	been done since then.			2011		
	_	TAR (Treatment					
		Record) indicated the					
	abdominal treatn	nent was set up initially					
	to be done on the	e day (7:00 a.m3:00					
	p.m.), evening (3	:00 p.m11:00 p.m.) and					
	night (11:00 p.m.	7:00 a.m.) shifts but					
	was changed to b	be done at 6:00 a.m., 2:00					
	p.m. and 10:00 p						
		cumentation the 6:00					
		treatments were done on					
	8/10/11.						
	During interview	y, on 9/13/11 at 10:00					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EK8J11

Facility ID: 000153

If continuation sheet

Page 7 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S		
		155249	B. WIN			09/14/20	011
	PROVIDER OR SUPPLIER O TRANSITIONAL C	CARE AND REHAB-FORT WAYN	NE	6006 BF	DDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE VAYNE, IN46815	1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Nursing) indicate	(Assistant Director of ed the night and day shift 0/11, were "missed" but					
	all the following	treatments had been					
	done.						
	She indicated the						
	_	it was determined that					
		nderstanding between ON indicated the day					
		e wound nurse was going					
	_	nts and she did not do					
	them.						
	2. The closed clin	nical record of Resident					
		I on 9/12/11 at 3:00 p.m.					
	and indicated the	resident was admitted to					
	the facility on 7/2	22/11 with diagnoses					
	which included b	out were not limited to,					
	•	t diabetes mellitus, and					
		nt #D was discharged to					
	home on 8/4/11.						
	The August and S	September 2011 MAR					
	(Medication Adn	ninistration Record)					
	indicated the resi	dent was to have blood					
	_	ore meals, at bed time					
		The MARs indicated if					
	_	vas less than 60 and the					
	_	onsive give 4 ounces of					
		notify the physician for					
	further orders.						
	On 8/2/11 at 2:11	a.m., progress notes					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155249		(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE COMP 09/14/2	LETED	
	PROVIDER OR SUPPLIEI	CARE AND REHAB-FORT WAYN	6006	TADDRESS, CITY, STATE, ZIP BRANDY CHASE COVE WAYNE, IN46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL SILSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	indicated Reside well and the resi low at 43. The reensure and "Res (Within Normal There was no do physician was not indicated the blowas 95. There we flow sheet indicated the blow sheet indicated the	ent #D was not feeling dent's blood sugar was esident was given a can of (Resident) now WNL Limit)"				
	observed administravenous antilline. The access covered with a g PICC line had a The resident ind been replaced or needed a dressing.	t 10:00 a.m. LPN #1 was stering Resident E's biotic, Vancomycin. PICC site was observed to be gauze dressing and the double lumen. icated her PICC line had a 9/11/11 and she felt she ag change to the PICC site. ord of Resident # E was 2/11 at 11:00 a.m. and				

´		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155249	A. BUI	LDING	00	COMPI 09/14/2	
		100249	B. WIN			09/14/2	.011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
KINIDDEI	D TDANSITIONAL C	CARE AND REHAB-FORT WAYN	ı⊏		RANDY CHASE COVE VAYNE, IN46815		
			\	<u> </u>	VATIVE, IN 40013		
(X4) ID PREFIX				ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	<u> </u>	dent was admitted to the					D.III.2
		agnoses which included					
	1 ,	ited to, an infected left					
	knee and diabete	-					
	Kilee and diabete	3.					
	The Sentember 2	011, Midline, CVAD					
	(Central Venous						
	`	Form indicated the					
		tion site dressing should					
		y seven days and as					
	needed.	seven days and as					
		ed the injection caps					
		ed every seven days with					
	ľ	and as needed. The form					
	1 -	the external PICC line					
		e measured. There was					
		n the injection caps had					
		the external catheter					
	measured betwee						
)					
	During interview	y, on 9/13/11 at 1:00 p.m.,					
	RN #2 indicated						
		CC dressing. RN #2					
		not change the injection					
		nanged the dressing.					
	_	<u> </u>					
	during interview.	on 9/14/11 at 9:00 a.m.,					
	·	indicated the facility					
	1	rmacy guidelines for					
	•	Manager #3 indicated					
	the external PICO	C catheter should be					
	measured and PI	CC access caps should be					
	changed at least	every week with the					
		. Unit Manager #3					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155249		(X2) MU A. BUIL B. WINC	DING	nstruction 00	(X3) DATE (COMPL 09/14/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	 	p. Wilk	STREET A	DDRESS, CITY, STATE, ZIP CODE	ļ	
KINDRFI	D TRANSITIONAL (CARE AND REHAB-FORT WAYN	IF		RANDY CHASE COVE VAYNE, IN46815		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	·		(X5)
PREFIX	FIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	indicated this ha	d not been done.					
	9/12/11 at 1:00 It diagnoses include to, depression, a On 9/7/11, a phy indicated Reside constipation, about On 9/7/11, a phy Relistor (an antimate was to be given thours. The Medication dated September 9/10/11 and 9/12 medication Relist given. On 9/13/11 at 10 Director of Nursin regard to the rather which was circle and 9/12/11. The medication Relist and the Nurse or forgot to call the	ecord was reviewed on P.M. Resident I's led but were not limited inxiety, and chronic pain. It is sician progress note ent #I was experiencing dominal pain and nausea. It is is order indicated inausea medication) 12 mg is subcutaneously every 48 Administration Record indicated on electron was circled as not experiencing as a subcutaneously every 48 Administration Record indicated on electron was circled as not experienced as not experienced as not experienced in edication, Relistor, ed as not given on 9/10 indicated the experienced in the facility in Saturday got busy and pharmacy and notify the					
	physician.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/14/2011
NAME OF P	PROVIDER OR SUPPLIER		I	ADDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE	
KINDREI	O TRANSITIONAL C	CARE AND REHAB-FORT WAYNE		WAYNE, IN46815	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
IAG		relates to Complaint	TAG	DEPILIENCY	DATE